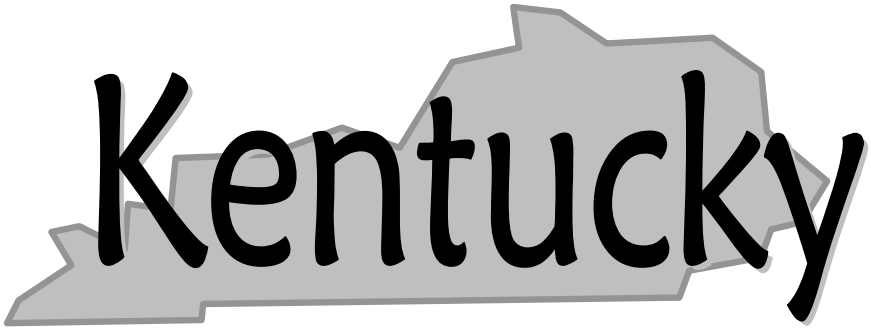
2010 ANNUAL SURVEY OF MAGNETIC RESONANCE IMAGING (MRI) EQUIPMENT AND SERVICES



January 1, 2010 - December 31, 2010

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HEALTH POLICY
275 EAST MAIN STREET 4 W-E
FRANKFORT, KY 40621

Completion required by 900 KAR 20:008 (rev 10-15-03) and 900 KAR 6:125

2010 Annual Survey of
Magnetic Resonance Imaging (MRI) Equipment and Services

INTRODUCTION

The accuracy and completeness of the data reported in this survey are essential to the process of health planning in Kentucky. It also represents the data requirements as set forth in 900 KAR 20:008 (rev 10-15-03) and 900 KAR 6:125. All items must be completed with actual tabulated data before this registration will be considered acceptable. Surveys are due by March 15, 2011.

You are responsible for the accuracy of the data reported in this survey. Please double check all entries. Retain a copy of the completed survey for your files. Annual data is required to be submitted via the secure data web page: **https://apps.chfs.ky.gov/OHPSurvey/Default.aspx**. Paper surveys are no longer accepted as an official submission. All surveys must be submitted via the internet. Failure to submit data timely and correct will result in the Office of the Inspector General being contacted regarding a licensure deficiency.

If there are any questions concerning the preparation of this survey, please contact: Beth Morris at betha.morris@ky.gov.

Office of Health Policy
Cabinet for Health and Family Services
(502)564-9592 or (502)564-9589

Certificate of Need Approved MRI Registry Registration

License Number: _____

Name of Facility: _____
Address: _____

City: _____ State: _____ Zip: _____

Contact Person(s): _____
Name
_____ _____
Phone Email
_____
Name
_____ _____
Phone Email

Owner of MRI Unit if different than name of facility:
_____

Certificate of Need Approved MRI Registry

License number: _____

Reporting period is for January 1, 2010 through December 31, 2010.

If less than twelve (12) months of operation, give beginning and ending date(s) in 2010_____

Total MRI Procedures: Mobile _____ Total MRI Patients: Mobile _____
Fixed _____ Fixed _____
Total _____ Total _____

Total number of hours per week facility is operational: _____

Check Service Type with an (F), (M) or (H): Freestanding __ Mobile __ Hospital __
(Please check box according to who holds the CON, example: a hospital that uses a mobile, but holds the CON is a hospital based, not a mobile.)

Number of MRI units stationed on site: Mobile___ Fixed___ Total___

Provide make, model and serial number of each unit:
Make: _____ Model: _____ Serial # _____
Make: _____ Model: _____ Serial # _____
Make: _____ Model: _____ Serial # _____
Make: _____ Model: _____ Serial # _____

Comments: _____
_____
_____

Mobile units must submit a separate report for each authorized location served on the lines below.
*Number of hours is per week each unit provides service to that location.
**Mobile units only complete this section.

County Served	**Location**	**# Procedures**	**# Units On-Site**	**# Hours Per Wk***	**Patients**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Certificate of Need Exempt MRI Registry Registration

Name of facility: _____

Owner of MRI Unit: _____

Location of Unit:

_____
Address

_____ _____ _____
City State Zip

Contact Person(s): _____ _____
First Name Last Name

_____ _____
Phone Email

_____ _____
First Name Last Name

_____ _____
Phone Email

Certificate of Need Exempt MRI Registry

Reporting period is for January 1, 2010 through December 31, 2010.

If less than twelve (12) months of operation, give beginning and ending date(s) in 2010_____

Total MRI Procedures: Mobile _____ Total MRI Patients: Mobile _____
Fixed _____ Fixed _____
Total _____ Total _____

Total number of hours per week facility is operational: _____

Check Service Type with an (F), (M) or (H): Freestanding __ Mobile __ Hospital __

Number of MRI units stationed on site: Mobile___ Fixed___ Total___

Provide make, model and serial number of each unit:
Make: _____ Model: _____ Serial # _____
Make: _____ Model: _____ Serial # _____
Make: _____ Model: _____ Serial # _____
Make: _____ Model: _____ Serial # _____

Comments: _____
_____
_____

Mobile units must submit a separate report for each authorized location served on the lines below.
*Number of hours is per week each unit provides service to that location.
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County Served	**Location**	**# Procedures**	**# Units On-Site**	**# Hours Per Wk***	**Patients**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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CERTIFICATION OF DATA

On behalf of the administration or physician _____, I certify that the information contained in this report is complete and accurate. After reviewing the information contained in this report, I hereby submit it as an official record of the activities required under 900 KAR 20:008 (rev 10-15-03) and 900 KAR 6:125.

Signed_____Date_____

Title_____

Phone_____ Email Address_____

NOTICE: Please review the data entered on this survey. Check that all questions have been answered accurately and in full. If any part of this survey is not clear to you, please call the Office of Health Policy at (502) 564-9592 or email betha.morris@ky.gov before submitting data. Once data has been received, edited, and published by this office, no changes will be made to the published report.